|  |  |
| --- | --- |
| Family Name |  |

|  |  |
| --- | --- |
| EHA ID No. |  |

|  |
| --- |
| **Children subject to the Early Help Assessment who need to be closed** |
| Name |  | DOB |  |
| Name |  | DOB |  |
| Name |  | DOB |  |
| Name |  | DOB |  |

|  |
| --- |
| **Children subject to the Early Help Assessment who need to remain open** |
| Name |  | DOB |  |
| Name |  | DOB |  |
| Name |  | DOB |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Lead Professional Name |  | Role |  |
| Contact Telephone Number |  | Organisation |  |
| Date |  |

|  |
| --- |
| **Presenting Family Issues (tick all applicable)** |
| **☐** Crime / ASB**☐** Education **☐** Children needing help  | **☐** Domestic Violence and Abuse**☐** Employment/finances **☐** Health (including mental health)**☐** Other reasons  |

|  |
| --- |
| **Type of closure** |
| **☐** EHA to close all family members **☐** EHA to close some family members but continue with others (please ensure named above) |

|  |
| --- |
| **Reason for closure** |
| **☐** Outcomes achieved**☐** Moved out of County(Consent to share with new area? Yes/No)**☐** Referral accepted by Child in Need/Child Protection**☐** Withdrawal of consent | **☐** Deceased**☐** Young Person/Family no longer engaged with process**☐** Other reason……… please state below |
| **Outcomes Achieved (please ensure you complete this section)** |
| **Details to be completed with the family wherever possible** |
| **c)** How effective has the Early Help process been in meeting the child/young person/family needs? | **☐ Fully effective****☐ Partially effective****☐ Not effective** |
| **On a scale of 1 to 5 can you rate how successful you feel the Early Help Assessment has been?****Lead Professional**1 2 3 4 5Not successful  Very successful**Parent/Carer**1 2 3 4 5Not successful  Very successful**Young person**1 2 3 4 5Not successful Very successful |
| **Any comments?…….** |
| **If you have contacted the Early Help First Contact Team or Early Help Locality for support?**Early Help First Contact **Yes/No** Early Help Locality Team **Yea/No****Was this useful** 1 2 3 4 5 NANot at all Very useful |

|  |
| --- |
| Child/young person’s comments: |

|  |
| --- |
| Parents/Carers comments: |

|  |  |  |
| --- | --- | --- |
| Child/Young person’s name | Child/Young person’s signature | Date |
| Parents/Carers name | Parents/Carers signature | Date |
| Lead Professional name | Lead Professional signature | Date |